Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS538HHA	A. BUILDING _____ B. WING _____	05/22/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY HEALTHCARE SERVICES	1701 W. CHARLESTON BLVD., SUITE 150 LAS VEGAS, NV 89102

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H 00	INITIAL COMMENTS This Statement of Deficiencies was generated as the result of a State licensure survey conducted from May 21, 2009 to May 22, 2009. The state licensure survey was conducted in accordance with Chapter 449, Home Health Agencies, adopted by the State Board of Health November 28, 1973, last amended November 17, 2005. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. The census was 1212. Fifteen patient files were reviewed. A Plan of Correction (POC) must be submitted. The POC must relate to the care of all patients and prevent such occurrences in the future. The intended completion dates and the mechanisms established to assure ongoing compliance must be included. Monitoring visits may be imposed to ensure on-going compliance with regulatory requirements. The following regulatory deficiencies were identified:	H 00		
H152 SS=F	449.782 Personnel Policies A home health agency shall establish written policies concerning the qualification, responsibilities and conditions of employment for	H152		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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H152	Continued From page 1 each type of personnel, including licensure if required by law. The written policies must be reviewed as needed and made available to the members of the staff and the advisory groups. The personnel policies must provide for: 6. The maintenance of employee records which confirm that personnel policies are followed; This Regulation is not met as evidenced by: NRS 449.179 (3): Initial and periodic investigations of criminal history of employee or independent contractor of certain agency of facility. 3. The administrator of, or the person licensed to operate, an agency to provide personal care services in the home, a facility for intermediate care, a facility for skilled nursing or a residential facility for groups shall ensure that the criminal history of each employee or independent contractor who works at the agency or facility is investigated at least once every 5 years. The administrator or person shall: (a) If the agency or facility does not have the fingerprints of the employee or independent contractor on file, obtain two sets of fingerprints from the employee or independent contractor; (b) Obtain written authorization from the employee or independent contractor to forward the fingerprints on file or obtained pursuant to paragraph (a) to the Central Repository for Nevada Records of Criminal History for submission to the Federal Bureau of Investigation for its report; and (c) Submit the fingerprints to the Central Repository for Nevada Records of Criminal History.	H152		

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H152	Continued From page 2 Based on employee file review and staff interview, the facility failed to comply with NRS 449.179 for 1 of 19 sampled employees (#13). Findings include: Record review of Employee #13's file revealed, Employee #13 was hired on 11/13/08. Employee #13's file did not have results of fingerprint background check as required by NRS 449.179 (3). Interview with the agency's President on 5/20/09 revealed, Employee #13's fingerprints were completed but were not mailed out. The agency's President was unable to verbalize why the cards were not sent to the Central Repository. Severity: 2 Scope: 3	H152		
H167 SS=A	449.788 Services to Patients 2. Services must be supplied only by qualified personnel and under the supervision of a physician licensed to practice in this state. Qualifications include licensure, registration, certification or their equivalent, as required by state or federal law, for each of the following disciplines: (a) The professional registered nurse must hold a state license. (b) The practical nurse must hold a state license (c) The home health aide must hold a certificate as a nursing assistant issued by the state board of nursing. (d) The physical therapist must be registered in this state.	H167		

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H167	Continued From page 3 (e) The occupational therapist must meet the requirements of the American Occupational Therapy Association or the equivalent thereof. (f) The speech therapist must hold a certificate from the American Speech and Hearing Association or the equivalent thereof. (g) The social worker must be licensed pursuant to chapter 641B of NRS. (h) The nutritionist must have a bachelor of science degree in home economics in food and nutrition or the equivalent thereof. (i) The inhalation therapist must be registered by the American Association of Inhalation Therapists or the equivalent thereof. This Regulation is not met as evidenced by: Based on record review, the Nurse Practice Act and staff interview, the agency nurse failed to identify herself by her appropriate title in 2 of 15 patient records (#14 and #11). Findings include: The agency admitted Patient #14 on 5/8/09. Patient #14's diagnoses included antepartum diabetes and asthma. A skilled nurse completed an assessment for an initial visit on 5/8/9, a progress note on 5/8/09, a routine visit on 5/13/09, a progress note on 5/16/09, and a routine visit on 5/19/09. On 5/22/09 in the morning, clerical staff indicated the skilled nurse was a registered nurse. The five instances of documentation listed above failed to indicate a licensed title after the skilled nurse's signature. NAC 632.249 1. Each registered nurse, licensed practical	H167		

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H167	Continued From page 4 nurse, certified nursing assistant, nursing student, and nurse certified in an advanced specialty shall identify himself by his appropriate title: a. When he records information on a record; ... The same registered nurse above signed an expected outcome on a plan of care for Patient #11 dated 5/8/09. The skilled nurse's signature lacked her title. Severity: 1, Scope: 1	H167		
H180 SS=C	449.793 Evaluation by Governing Body 6. The governing body shall provide for a quarterly review of 10 percent of the records of patients who have received services during hte preceding 3 months in each services area. The members of the committee must include an administrative representative, a physician, a registered nurse and a clerk or librarian who keeps records. The clerk or librarian shall review the clinical records to ensure that they are complete, that all forms are properly filled out and that documentation complies with good medical practices. The committee shall determine whether the services have been provided to the patients in an adequate and appropriate manner by all levels of service. The committee shall record any deficiencies and make necessary recommendations to the administrator. If the branch offices are small, two or more offices may establish one committee to review cases from each are. Each subunit agency must establish a committee to review cases within its area. Minutes of the committee's meetings must be documented and available for review. This Regulation is not met as evidenced by: Based on record review and staff interview, the agency failed to provide documented evidence it	H180		

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H180	Continued From page 5 reviewed 10% of patient records in each service area for the first quarter of 2009. Findings include: On 5/22/09 at 2:30 PM, the Professional Services Director (PSD) provided the following audit information for the first quarter of 2009: social services, regulatory review, and wound indicator. On 5/22/09 at 4:30 PM, The PSD failed to indicate how the agency met the required review of 10% of patient records in each service area in relation to its census for the first quarter of 2009. The information the PSD presented lacked documented evidence demonstrating the agency reviewed 10% of patient records in each service area in relation to its census for the first quarter of 2009. On 5/22/09 at 4:35 PM, the Administrator failed to indicate how the agency met the required review of 10% of patient records in each service area in relation to its census for the first quarter of 2009. Severity: 1 Scope: 3	H180		
H186 SS=D	449.797 Contents of Clinical Records Clinical records must contain: 3. A clinical summary from the hospital, skilled nursing facility or other health service facility from which the patient is transferred to the home health agency. This Regulation is not met as evidenced by: Based on policy review, record review and staff interview, the agency files lacked a history and physical and/or clinical summary from discharging facilities for 3 of 15 patients (#2, #4,	H186		

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H186	Continued From page 6 and #11). Findings include: According to agency Policy #7.012 (effective 2/21/01) Contents Of The Clinical Record, a patient's file should include "information as to whether home health services are after hospitalization in a hospital, skilled nursing facility or other health service facility and, if so, the dates of admission and discharge from these facilities." The files for Patient #2, #4, and #11 lacked histories and physicals and/or clinical summaries from their discharging facilities. On 5/22/09 in the afternoon, interview with the clerical staff indicated Patient #2, #4, and #11 lacked outstanding histories and physicals and/or clinical summaries. Severity: 2 Scope: 1	H186		
H190 SS=D	449.797 Contents of Clinical Records 7. Therapist's notes, if applicable, stating the rehabilitative procedures, progress and the types, duration and frequency of the modalities rendered. This Regulation is not met as evidenced by: Based on record review, policy review and staff interview, the agency failed to provide physical therapy documentation for 2 of 15 patients (#9 and #12). Findings include: The agency admitted Patient #9 on 1/21/09. Patient #9's diagnoses included status post motor	H190		

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H190	Continued From page 7 vehicle accident with bilateral ankle fractures, gait abnormality, and pregnancy. On 3/22/09, Patient #9's plan of care indicated a physical therapy evaluation. Patient #9's file contained documented evidence of physical therapy visits on 3/24/09, 3/26/09, 3/31/09, 4/8/09, 4/10/09, and 4/13/09. Each visit document indicated twice weekly physical therapy visits. On 4/8/09, a skilled nurse indicated Patient #9 received physical therapy visits three times weekly. On 5/19/09, a skilled nurse indicated the agency recertified Patient #9 to continue with physical therapy. On 5/22/09 in the morning, Patient #9's file lacked the following documented evidence for the certification period 3/22/09 to 5/20/09: 1. A physical therapy evaluation ordered on 3/22/09 2. Physical therapy visits dated from 4/14/09 to 5/22/09 3. Physician orders for physical therapy visit frequency 4. A physical therapy discharge summary On 5/22/09 during an interview in the morning, the Professional Services Director and clerical staff indicated the physical therapist responsible for the four items above would try to deliver the above documented evidence regarding physical therapy services. The agency admitted Patient #12 on 4/25/09.	H190		

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H190	Continued From page 8 Patient #12's diagnoses included pathological hip fracture, total hip fracture, and bone/breast cancer. On 4/25/09, Patient #12's plan of care indicated twice weekly physical therapy visits between 5/3/09 and 5/16/09. Patient #12's file lacked documented evidence of physical therapy visits or a physician's order discontinuing them between 5/3/09 and 5/16/09. Physical therapy documented a visit on 5/18/09 and discharged Patient #12. On 5/22/09 at 2:00 PM, interview with clerical staff indicated the following when asked about Patient #12's missing physical therapy visits: "what you have is what we have. There aren't any more copies." Agency Policy #7.012, effective 2/21/01 and revised 5/27/08, indicated a patient's clinical record should include therapists' notes, if applicable, stating the rehabilitative procedures, progress and the types, duration and frequency of the modalities rendered." The agency's policy "Entries Into Clinical Records", effective 4/1/99 and revised 3/1/06, indicated "the visit documentation will be completed the day of care provided to the patient. All notes will be written and/or data entered, and synchronized at the end of shift." Severity: 2 Scope: 1	H190		
H195 SS=A	449.800 Medical Orders 2. Initial medical orders, renewals and changes of	H195		

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H195	Continued From page 9 orders for skilled nursing an d other therapeutic services submitted by telephone must be recorded before they are carried out All medical orders must bear the signature of the physician who initiated the order within 20 working days after receipt of the oral order. This Regulation is not met as evidenced by: Based on clinical record review and agency policy review, the agency failed to obtain signatures within 20 working days on a physician's order for 2 of 15 patients (#5 and #10). Findings include: The agency admitted Patient #5 on 5/21/08. Patient #5's diagnoses included vascular graft, status post venous catheter, lower extremity deep vein thrombosis/embolism, peripheral vascular disease, hypertension, and diabetes. On 5/21/08, the agency initiated Patient #5's plan of care. The agency failed to receive the physician's signature on the plan of care until 6/30/08. On 5/21/09 in the afternoon, Patient #10's file contained verbal orders for physical therapy treatments initiated on 3/19/09 and 3/22/09. Both orders lacked a physician's signature. According to the agency's policy "Contents Of The Clinical Record" guideline, effective 2/21/01 and revised 5/27/08, the clinical record should include "legible, complete and individualized diagnostic and therapeutic orders signed the physician within 20 working days (cross reference Policy #3-002 and 4-003)." Severity: 1 Scope: 1	H195		

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H198	Continued From page 10	H198		
H198 SS=D	449.800 Medical Orders 6. Specific orders must be given for: (a) Rehabilitative and restorative care such as physiotherapy; (b) Skilled nursing and home health aide care; (c) Nutritional needs; (d) The degree of activity permitted; (e) Dressings and the frequency of change; (f) The instruction of a member of the family in technical nursing procedures; and (g) Any other items necessary to complete a specific plan of treatment for the patient. This Regulation is not met as evidenced by: Based on record review and staff interview, the agency failed to provide documented evidence of a physician's order for physical therapy visits/visit frequency for 2 of 15 patients (#9 and #10). Findings include: The agency admitted Patient #9 on 1/21/09. Patient #9's diagnoses included status post motor vehicle accident with bilateral ankle fractures, gait abnormality, and pregnancy. On 3/22/09, Patient #9's plan of care indicated a physical therapy evaluation. Patient #9's file contained documented evidence of physical therapy visits on 3/24/09, 3/26/09, 3/31/09, 4/8/09, 4/10/09, and 4/13/09. Each visit document indicated twice weekly physical therapy visits to continue. On 4/8/09, a skilled nurse indicated Patient #9 received physical therapy visits three times weekly.	H198		

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H198	Continued From page 11 On 5/19/09, a skilled nurse indicated the agency recertified Patient #9 to continue with physical therapy. On 5/22/09 in the morning, Patient #9's file lacked documented evidence of a physician's order for physical therapy visit frequency for the certification period 3/22/09 to 5/20/09. On 5/22/09 in the morning during an interview, the Professional Services Director and clerical staff indicated the physical therapist responsible for the lack of a physician's order above would try to deliver the above documented evidence regarding physical therapy services. On 5/22/09 at 2:00 PM, during an interview the clerical staff indicated the following when asked about the above missing physician's order: "what you have is what we have. There aren't any more copies." The agency admitted Patient #10 on 3/16/09. Patient #10's diagnoses included systemic lupus erythematosus, myalgia, pericardial disease, and hypertension. Patient #10's file contained a physician's order for twice weekly physical therapy visits between 3/22/09 and 4/11/09. Patient #10's file contained documented evidence of physical therapy visits or attempted visits on 3/24/09, 3/25/09, 4/1/09, 4/3/09, 4/7/09, 4/9/09, 4/14/09, and 4/16/09. Patient #10's file lacked documented evidence of a physician's order for physical therapy visits on 4/14/09 and 4/16/09.	H198		

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H198	Continued From page 12 On 5/22/09 at 2:00 PM, during an interview the clerical staff indicated the following when asked about the above missing physician's order: "what you have is what we have. There aren't any more copies." Severity: 2 Scope: 1	H198		
H200 SS=E	449.800 Medical Orders 8. New orders are required when there is a change in orders, a change of physician or following hospitalization. This Regulation is not met as evidenced by: Based on record review, policy review and staff interview, the agency failed to obtain a physician's order for changes in the plan of care for 5 of 15 patients (#5, #9, #10, #12, and #14). Findings include: The agency admitted Patient #5 on 5/21/08. Patient #5's diagnoses included vascular graft, status post venous catheter, lower extremity deep vein thrombosis/embolism, peripheral vascular disease, hypertension, and diabetes. On 5/21/08, Patient #5's plan of care indicated skilled nursing visits three times weekly for nine weeks. On 5/21/09, Patient #5's file documented twice weekly skilled nursing visits for three weeks before discharging the patient. Patient #5's file lacked documented evidence of a physician's order for a change in the plan of care. The agency admitted Patient #9 on 1/21/09. Patient #9's diagnoses included status post motor	H200		

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H200	Continued From page 13 vehicle accident with bilateral ankle fractures, gait abnormality, and pregnancy. On 5/22/09 in the morning, Patient #9's file lacked the following documented evidence for the certification period 3/22/09 to 5/20/09: 1. A physical therapy evaluation ordered on 3/22/09 2. Physical therapy visits dated from 4/14/09 to 5/22/09 3. Physician orders for physical therapy visit frequency 4. A physical therapy discharge summary On 5/22/09 in the morning, during an interview, the Professional Services Director and clerical staff indicated the physical therapist responsible for the four items above would try to deliver the above documented evidence regarding physical therapy services. On 5/22/09 at 2:00 PM, during an interview, the clerical staff indicated the following when asked about the above four items: "what you have is what we have. There aren't any more copies." Patient #9's file lacked documented evidence of a physician's order for a change in the plan of care. The agency admitted Patient #10 on 3/16/09. Patient #10's diagnoses included systemic lupus erythematosus, myalgia, pericardial disease, and hypertension. Patient #10's file contained a physician's order for twice weekly physical therapy visits between 3/22/09 and 4/11/09. Patient #10's file contained documented evidence	H200		

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H200	Continued From page 14 of physical therapy visits or attempted visits on 3/24/09, 3/25/09, 4/1/09, 4/3/09, 4/7/09, 4/9/09, 4/14/09, and 4/16/09. Patient #10's file lacked documented evidence of a physician's order for physical therapy visits on 4/14/09 and 4/16/09. On 5/22/09 at 2:00 PM during an interview, the clerical staff indicated the following when asked about the above missing physician's order: "what you have is what we have. There aren't any more copies." Patient #10's file lacked documented evidence of a physician's order for a change in the plan of care. The agency admitted Patient #12 on 4/25/09. Patient #12's diagnoses included pathological hip fracture, total hip fracture, and bone/breast cancer. On 4/25/09, Patient #12's plan of care indicated twice weekly physical therapy visits between 5/3/09 and 5/16/09. Patient #12's file lacked documented evidence of physical therapy visits or a physician's order discontinuing them between 5/3/09 and 5/16/09. Patient #12's file lacked documented evidence of a physician's order for a change in the plan of care. The agency admitted Patient #14 on 5/8/09. Patient #14's diagnoses included antepartum diabetes and asthma. On 5/8/09, Patient #14's plan of care indicated	H200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS538HHA	A. BUILDING _____ B. WING _____	05/22/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H200	Continued From page 15 twice weekly skilled nursing visits for the week of 5/10/09. Patient #14's file contained documented evidence of one skilled nurse visit dated 5/13/09. Patient #14's file lacked documented evidence of a second skilled nursing visit or a physician's order discontinuing it between 5/10/09 and 5/16/09. Patient #14's file lacked documented evidence of a physician's order for a change in the plan of care. Severity: 2 Scope: 2	H200		